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Why S&P and Moody's Are Getting it Wrong on Healthcare

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Ratings agencies have been overly optimistic in their upgrade of the healthcare sector, choosing to look at improvements in subgroups as a predictor for the entire sector. A quick review shows the flaws in this logic. Drawing on the temporary relief we're now seeing in the sector, the agencies are allowing the benefits of macro trends to cloud their judgment of the 18-month outlook.

There are three primary reasons for the healthcare upgrade:

- Reduction in Bad Debt: The Affordable Care Act has reduced bad debt and increased patient volume.
- Widespread Cost Cutting: Health systems are currently enjoying benefits from a multi-year focus on cost-cutting.
- Fewer Capital Intensive Initiatives: Costly electronic healthcare records upgrades are complete, freeing capital.

In total, these factors have led to improved operating performance over the past two years. The problem is that these positives are split unevenly between the haves and the have nots: Large, urban-based health systems are reaping substantial benefits from improved payor mix and enhanced operating efficiencies, while many independent community hospitals continue to struggle. Rural and secondary markets have high unemployment and aging demographics that will continue to challenge hospitals in these markets, given the current economic outlook and demographic trends. Even ratings agencies note the long-term challenges.

Reduction in Bad Debt, Increase in Patient Volume

With improvements in medicine, patients require shorter hospital stays and, often, fewer treatments. As a society, I think we can say this is a net positive. However, this creates a fundamental financial problem: the number of days, and therefore dollars, a patient pays is decreasing, while the cost to maintain a hospital is increasing. Unless a hospital is able to grow its patient base, it simply can't keep up.

This base is growing in some areas. The urban shift has swelled the potential patient base in metropolitan areas, allowing these hospitals to thrive. The positive impacts of this are part of what the ratings agencies were highlighting in the upgrade.

The flip side is that rural hospitals are losing young, healthy patients, as this cohort migrates to cities. Rural hospitals work disproportionately with elderly patients, who tend to be sicker, requiring more care, and often rely on government programs. The one-two punch hurts community hospitals more noticeably than the urban shift helps urban hospitals.

Even hospitals that have reaped the ACA's payor mix and volume benefits have yet to deal with the second part of the plan: penalties for patient quality. Under ACA, penalties for missing quality metrics continue to escalate, creating further cash flow challenges for community hospitals. In addition, cuts in DSH payments, created to offset the costs of supporting a Medicaid-based population, will begin to accelerate in 2016.

At the same time, the transition to bundled payments and other value-based reimbursements continue to increase, introducing additional risk into hospital financials that did not previously exist.

Adding insult to injury, half of community hospitals are in markets that haven't fully accepted the ACA. This means they haven't benefitted from short-term, revenue-and-volume-enhancing initiatives of the ACA, but will begin to experience revenue reductions from its new policies this coming year.

In short: This year we have seen the revenue upside from ACA initiatives, but next year we will begin to feel the cost cutting policies meant to "bend the cost curve."

Widespread Cost-Cutting

Over the past decade, most health systems employed Group Purchasing Organizations to manage supply costs and upgrade to industry benchmarks. The GPOs streamlined staffing and transitioned employees away from benefit retirement plans. Hospitals have been able to grow revenues while reducing operating costs, expanding operating margins. However, the opportunity to further reduce operating expenses is fast disappearing in an environment of 5% unemployment and double-digit increases in health insurance premium and drug costs. Many health systems will see operating expenses rise at a much faster rate than revenue within the next year.

Fewer Capital Intensive Initiatives

The migration to electronic health systems over the past five years created operational challenges and diverted capital spending for large and small hospitals alike. The good news is that most health systems are now more efficient in patient care and operations from these upgrades. However, many now face a backlog of deferred capital investments. This is especially painful in an era of new technology, when older community hospitals are quickly becoming functionally obsolete. A significant number of community hospitals will need to undertake expensive capital initiatives in the near-term to remain competitive. If they don't, they may be relegated to providing only basic community health services or, worse, go under.

It seems that ratings agency predictions for healthcare are imitating their behavior before the credit crisis: short-sighted and overly optimistic.

Gregory F. Hagood, CFA, is a senior managing director at SOLIC Capital

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